



PHARMACY REQUEST FOR AN ADJUSTMENT
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 640 (Rev. 06-2002)

INSTRUCTIONS: Use one form for each prescription.

(1) Reason for Request: <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> A. Underpayment <input type="checkbox"/> B. No Payment</div><div><input type="checkbox"/> C. Overpayment <input type="checkbox"/> D. Corrected Billing</div><div><input type="checkbox"/> E. Other _____</div></div>							
(2) Provider's Name: **Pharmacy Provider**				(4) Recipient Identification:			
Provider's Address:				I.D. Number: **000-12-3456**			
City:		State:	Zip Code:	Patient's Name: **Smith, John**			
(3) Provider's Number: **2xxxx**				Case Number: **00-12345-000**			
				Birth Date:			
(5) Recipient's Residence: <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> ICF/MR</div><div><input type="checkbox"/> Custodial Care <input type="checkbox"/> Swing Bed <input type="checkbox"/> Private Residence</div></div>			(6) Remittance Advice Date: **01/05/05**		(9) Control Number: (From Remittance Advice) **4005123456789**		
(7) Authorization Number:							
(8) Prescribing Doctor's Name or Number:							
FOR EACH BLOCK, DETAIL SPECIFICS AS ON AUTHORIZATION FORM & REMITTANCE ADVICE							
(10) Date of Service	(11) Rx Number	(12) Rx Date	(13) Drug Name, Conc. & Mfg.	(14) NDC Number	(15) Quantity (Metric)	(16) Bill Amount	(17) Paid Amount
12/01/04	**1234567**	**11/30/04**	**Lantus**	**01234567890**	**30**	**\$216.00**	**\$50.00**
(18) State Use Only		(19) Explanation/Remarks: (Corrected information is to be entered in this space. Be complete and descriptive.) **Explain what needs to be corrected.** **Example: Quantity should be 90.**					
(20) Mail To: Medical Services North Dakota Department of Human Services 600 E Boulevard Ave Dept 325 Bismarck ND 58505				(21) Provider's Signature: **Pharmacy Provider**			
				Date: **01/15/05**			
				Telephone Number:			
Copy: Retained by Pharmacy							



(1) Reason for Request: <input type="checkbox"/> A. No Payment Received <input type="checkbox"/> B. Overpayment <input type="checkbox"/> C. Underpayment <input type="checkbox"/> D. Corrected Billing Attached <input type="checkbox"/> E. Paid to Wrong Provider <input type="checkbox"/> F. Cannot Identify Beneficiary on Explanation of Benefits <input type="checkbox"/> G. Lost Check <input type="checkbox"/> H. Other (Please Clarify Under Remarks)												
(2) Recipient Block: a. ID No. 000-99-9999 (must be 9 digits) b. Patient's Name Smith, John c. Case Number						(4) Claim's Internal Control Number <div style="text-align: center; border: 1px solid black; padding: 5px;"> 1005123456789 (MUST BE 13 DIGITS) </div>			(5) (6) Provider No.: <div style="text-align: center; border: 1px solid black; padding: 5px;"> 12345 </div>			
(3) Provider's Name: Medical Office Address						(7) Remittance Advice Date: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> 12 MO </div> <div style="text-align: center;"> 23 DAY </div> <div style="text-align: center;"> 04 YEAR </div> </div>						
(8) Dates of Service: <div style="display: flex; justify-content: space-between;"> <div> From Mo Day Yr </div> <div> Thru Mo Day Yr </div> </div>						(9) Units	(10) Place of Service	(11) Procedure/Ancillary/ Accommodation Code	(12) Modifier	(13) Tooth Number/ Tooth Surface	(14) Amount Billed	(15) Amount Paid
<div style="display: flex; justify-content: space-between;"> <div> 12 01 04 </div> <div> 12 01 04 </div> </div>						<div style="text-align: center;">1</div>		<div style="text-align: center;">XXXXX</div>			<div style="text-align: right;">\$99.99</div>	<div style="text-align: right;">\$50.35</div>
(17) Explanation/Remarks: <div style="border: 1px solid black; padding: 10px;"> <p>Explain why you are adjusting claim.</p> <p>Example: dates of service should be 12/10/04. Units should be 2. Billed amount should be 199.98.</p> </div>						<div style="text-align: center; border: 1px solid black; padding: 5px;"> (16) Total </div>		<div style="text-align: right; border: 1px solid black; padding: 5px;"> \$99.99 </div>		<div style="text-align: right; border: 1px solid black; padding: 5px;"> \$50.35 </div>		
<div style="border: 1px solid black; padding: 10px; text-align: center;"> Medical Services N.D. Department of Human Services 600 E. Boulevard Avenue Bismarck, ND 58505-0250 38435 </div>						(18) Provider's Signature: Date <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">03 MO</div> <div style="text-align: center;">24 DAY</div> <div style="text-align: center;">05 YEAR</div> </div> Telephone Number _____ By: _____						